

## FMLA DENIAL NOTIFICATION

|                  |  |               |  |
|------------------|--|---------------|--|
| To:              |  | Date:         |  |
| From:            |  | Title:        |  |
| Office Location: |  | Office Phone: |  |
| Office Address:  |  | Office Fax:   |  |

We received your request, or have gained knowledge of your need, to take leave under the Family and Medical Leave Act (FMLA) due to a serious health condition that makes you unable to perform the essential functions of your job. This is to inform you that you **are not** eligible for leave under the FMLA at this time. You may submit additional medical certification within 15 calendar days and your request will be reconsidered when the additional medical certification is received. If you are a Regular status employee, the Judiciary's Sick Leave Policy will govern your absence until there is a positive determination of your need for FMLA.

If you have any questions, please contact me at the above number.

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|--|------------------|--|
| You <b>are not</b> eligible for FMLA at this time because: |                  | You have not been employed by the State of Maryland for 12 months.   |
|  |                  | You have not <u>worked</u> at least 1,250 hours in the past 12-month period (does not include paid and unpaid leave/absences).   |
|  |                  | Your condition does not qualify as a serious health condition under FMLA.  |
|  |                  | You did not submit the required medical certification to support your request for FMLA leave.  |
|  |                  | Your medical certification is insufficient as indicated below. You may submit additional medical certification within 15 calendar days. Your request will be reconsidered when the additional medical certification is received. |
|  |                  | The medical certification is illegible.  |
|  |                  | The medical certification does not indicate that you need to be absent from work.  |
|  |                  | The medical certification does not include a prognosis, duration, treatment plan and/or frequency of incapacity.   |
|  |                  | The medical certification is not signed and/or dated by the health care provider.  |
|  |                  | The health care provider is not an approved provider under FMLA.   |
|  |                  | Other (explain):   |
|  |                  | Your family member is not eligible for inclusion under FMLA.   |
|  | Other (explain): |  |